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THE MADRAS CLINICAL JOURNAL

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JOURNAL OF THE MADRAS STATE BRANCH INDIAN MEDICAL ASSOCIATION
(With which is incorporated the "Miscellany")

XXV AUGUST 1958 No. 2

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JOURNAL OF THE MADRAS STATE BRANCH OF THE INDIAN MEDICAL ASSOCIATION

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Vol. XXV] AUGUST 1958 [No. 2

PAIN IN THE FOOT (*Contd.*)

by

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Hallux Valgus. Hallux valgus is not uncommon in the bare-footed Indian both male and female. Congenital variety in children is seen now and then. The hallux valgus problem is more common in women wearing high heels and narrow pointed shoes. The hallux valgus is probably initiated by an infective process like rheumatism.

If the foot with a high heel is radiographed, it is seen that the metatarsals are more or less vertical, the body-weight is thrown on the metatarsal arch. This throwing forward at each step produces rubbing of the plantar skin at the level of the heads of the metatarsals, distorts the metatarsal arch, crowds the toes in the front of the shoe, dorsiflexes the toes at the metatarsophalgeal joints. This leads to contractures of the long and short extensor muscles of the foot with stretching of the lumbricales and interossei. The high heels and the abnormal posture cause the metatarsals to "fan out". When the toes are dorsiflexed at the metatarsophalangeal joints in order to grip the shoes, the toes become flexed at the interphalangeal joints. The pointed shoe prevents the great toe being kept straight as the point of the shoe is lateral to the mid-line of the foot i.e. the central line of the second metatarsal and toe. The great toe is twisted inwards till the nail looks towards the medial side due to the action of the adductor transversus and obliqus hallucis which are inserted into the base of the phalanx of the great toe. The dislocation of the metatarso-phalangeal joint is caused by the pull of the tight extensor tendon on toes which are kept dorsiflexed by the high heels.

There are generally other changes in the foot associated with a hallux valgus and there may be flattening of the metatarsal arch with spreading of the metatarsals and formation of callosities on the plantar aspect. Valgus deformity and inward rotation of the big toe, formation of a bunion over an exostosis on the inner side of the first metatarsal are seen. The second toe lies under or over the big toe or is pushed laterally. If the second toe is under the big toe, it is a hammer toe and there is a painful corn on the dorsum of the proximal inter phalangeal joint. The outer three toes may be crowded together and may be

rigid. With loss of the metatarsal arch or reversal to a convexity there will be clawing of the toes. Distortion of the second metatarsophalangeal joint is seen. Flattening of the longitudinal arch is common. In the majority of the cases the cause of hallux valgus is flat foot. A hallux valgus does not usually develop without the accompaniment of a flat foot. Corn formation on the lateral aspect of the fifth toe is also seen.

Treatment of hallux valgus. Conservative measures are alterations in the shoe e.g. the inner side of the shoe should be straight, taking off pressure from the inner side of the head of the first metatarsal, support of the longitudinal arch of the foot and a metatarsal bar is attached to the under-surface of the sole half an inch broad and a quarter of an inch in depth. The bar is placed across the sole immediately behind the metatarsophalangeal joints. The attachment of a stud to the upper surface of the sole between the first and the second toe or the provision of a special compartment for the big toe is common in India and is an effective prophylactic measure. *Indications for operations in Hallux valgus.* Any patient who has a painful bunion over the inner side of the big toe joint with the deflection of the toe outwards causing the second toe to override it, is judged suitable. Operation is not performed in the presence of the inflammation. *Unsuitable occupations after operation are* an employment which requires prolonged standing, toe-dancing or professional foot-ball playing. Regarding operative intervention in hallux valgus, it has to be remembered that any procedure which may result in shortening the length of the longitudinal arch is bad as it weakens the foot. For this reason the head of the metatarsal bone should not be removed but it is recommended that the prominence on the inner side of the metatarsal head should be removed. If correction is not obtained by this procedure the base of the first phalanx is removed.

If there are osteophytes and osteoarthritic changes have taken place in the metatarsophalangeal joints, it is better to excise the head, so the operative procedure depends on the pathological changes inside the joint. The head of the metatarsal is removed but not any portion of the shaft, no part of the bunion itself is removed, if the bunion is cut away, there is a danger of skin becoming adherent to the bone and causing a painful scar. If the bunion is infected it should however be removed.

After treatment. Skin traction is applied to the big toe and fixed to the cross-bar of a cradle for extension. If extension is not applied the big toe shrinks back into the foot too much and may become stiff from fibrous ankylosis between the phalanx and the metatarsal. Patients may walk in a fortnight and wear a shoe in three weeks. The shoes are well-built with stout soles, ample width in the tread and straight on the inside. The patient may return to work in six weeks time.

Hallux Varus. This is a condition in which the great toe is deviated towards the middle line of the body. It is met with in infancy and may be associated with a slight degree of varus deformity. A congenital variety occurs and is a variety of pigeon toe which is applied to the habitual turning in of the feet in walking. The inward rotating may be associated with congenital equino varus or bow legs or with coxa, vara in which the neck of the femur is concave anteriorly. In a great majority of cases pigeon toe is usually symptom of weakening of the arch of the foot or of knockknee. This is referred to under the heading "Flat foot in children". It is often met with in elderly people in bare footed agricultural labourers and is associated with a weak foot. They are able to do hard work and the feet are quite useful. Hallux varus may result from trauma or fracture of

the head of the first metatarsal where the medial part of the head is depressed.

Treatment. The deformity of which it is a symptom should be corrected as genu-valgum, weakness of arch and of coxavara. It often remains as a deformity in cases of congenital talipes equino varus. This inward turning is associated with limitatory of the range of outward rotation at the hip joint. This should be overcome by stretching of the contracted part. The deformity in congenital talipes is often persistent and an apparatus to hold the feet in the proper attitude should be worn. In the traumatic variety an operation to correct the displacement is required. Otherwise they are not able to wear boots and will not be fit for military and such other duties. The deformity in old age may be left alone as the function is generally good. The majority of infantile types will get corrected.

Hammer Toe. The second toe is commonly affected because it is the longest of the other four and is liable to be displaced and cramped by any lateral displacement in the great toe. There is flexion of the proximal inter-phalangeal joint. The cause is a badly shaped and centrally pointed type of shoe.

Conservative methods of treatment.

1. The deformity is corrected by narrow strips of adhesive plaster: this is simple and the correction is progressive.
2. An insole provided with an elastic loop into which contracted toe is inserted. It is applied inside the stocking.
3. A light aluminium splint strapped under near the toe and extending from its tip to the metatarsophalangeal joint.

As a result of the hammer toe, there are corns at the points of maximum pressure one on the convexity of the interphalangeal flexion deformity and another on the tip of the terminal phalanx immediately below the nail. The corns disappear after the correction of the deformity.

The operative method of treatment is good. By a transverse incision on the dorsum of the flexed joint, after tenotomy of the contracted tendon, excision of a wedge of the joint and straightening of the articular surface is done. The toe is splinted so that ankylosis occurs at the point of excision. It is important to recognise the dorsal flexion of the metatarsophalangeal joint. Ligaments and capsule require free division ; the dorsal tendons require lengthening. Subsequent division of the plantar portion of the interphalangeal joint or joint capsule will relieve most cases.

Treatment after operation consists in keeping the toes straight ; the patient should rest in bed for atleast six weeks. Before the patient is allowed out for work, correct shoes should be ordered.

Hallux Rigidus. There is stiffness and pain in the joint of the great toe with a callous ridge in the inner side of the ball of the foot. There is inability to secure any degree of dorsiflexion in the metatarsophalangeal joint and this interferes with walking.

Etiological factors. Occasionally an injury to the joint or the neighbouring bones or rheumatism may produce a hallux rigidus. Commonly the condition is a result of an acute type of flat foot after an attack of debilitating illness such as influenza.

The line of weight bearing changes: Instead of passing between the heads of the second and third metatarsals, it passes medially towards the line of the first metatarsal head. Excessive weight bearing affects the metatarsophalangeal joint of the big toe. There are osteo-

arthritic changes and peri-articular fibrosis. In later stages a stiff joint results and this may be followed by the great toe fixed in plantar flexion due to the contraction of the flexor brevis hallucis. This is a painful condition and it may become associated with hammer toe and hallux malleus. Prophylaxis consists essentially in the correction of the underlying flat foot.

Treatment. Treatment consists in complete fixation of the affected joint; the pain disappears under this treatment. The shoe is corrected and the raising of the inside of the boot sole diminishes the pain. Manipulation of the joint under an anaesthetic is not helpful.

Operative treatment consists in excision of the base of the fist phalanx and the interposition of a flap of fascia taken from the medial aspect of the toe over the raw surface of the bone. The head of the metatarsal bone should not be removed as it will interfere with the stability of the longitudinal arch.

Hallux Malleus in plantar flexion. Plantar flexion of the great toe is common in India. It is due to the division of the extensor longus hallucis tendon and the tendon should be sutured. If the tendon is paralysed in infantile paralysis cases, the joint requires arthrodeisis Patients develop this condition due to the weight of the bed clothes during serious illness as typhoid, arthritis of joints and fractures. The condition should be looked for and prophylactic measures adopted to keep the toe in position by a plaster cast or cardboard splints moulded to the toe.

Foot disabilities due to fractures. Fractures of the second and third metatarsals may occur during walking as forced marches. Fractures of the fifth metatarsal at its base may occur during sudden eversion of the foot. Fractures of the metatarsals require during their treatment careful moulding of the plantar aspect of the foot; they lead to much pain and disability especially in fat people.

Metatarsalgia. The transverse arch may be strained or flattened. In this condition patients complain of pain at the matatarsophalangeal joints when the patient brings his weight to bear on the retrodigital pad of the sole. The pain is relieved by compressing the metatarsals proving that the fault lies in the breakdown of the transverse arch.

Treatment. A bar across the sole of the shoe throws the weight of the body more on the heel and thus relieved the strain on the transverse arch.

Ingrowing toe nail. Normally the toe nail is rectangular and the growing edge comes over the skin adjacent to the free border of the nail. The nail is often torn badly or cut too short and in the flat-footed hallux valgus patients with improper boots it is likely to give trouble. The nail bed may become infected.

Prophylaxis. The toe-nails should be cut straight across leaving projecting corners. If this is done ingrowing toe nail will not occur. It is better to keep the nails longer in those who have a tendency to suffer from infrowing nail.

Treatment. The downward curve of the nail from side to side should be converted into an upward curve. Nothing should be removed from the edge of the nail where the ingrowth is taking place. A groove is made in the centre of the nail with a broken glass piece. The shaving is continued until the centre line is quite thin and the pink nail bed shines through. The ingrowing edge of the nail is lifted up and pledgets of vaseline gauze are packed under it. Let the nail grow out. This preserves the full width of the nail. Watson Cheyne's operation consists in the removal of a wedge of nail about a quarter of an inch wide

together with the underlying nail bed and nail matrix and sufficient of the nail wall to exclude the ulcerated area. In the Winograd operation, a strip of nail and its matrix leaving intact the nail wall is excised. Simple avulsion of the nail was followed by very large percentage of recurrences. Excision of the whole nail and matrix gives freedom from recurrence. Wedge resection from the nail wall with the object of allowing more space for the ingrowing toenail is followed by recurrence. Cutting off the lateral edge of skin and keeping the nail elevated, touching copper sulphate daily for about ten days, cutting down a –V–in the middle of the nail and keeping it pared are also useful.

Tuberculosis of os-calcis, Talus and other bones require complete rest from weight-bearing, plaster casing or splinting and general nutritive and specific treatment with antibiotics. Feet suffer badly in Rheumatoid arthritis; pain is relieved by cortisone; deformities should be prevented. Where causes are not obvious reasons are not noticed attention should be devoted to the other causes of foot pain. Thrombo-angitis obliterans is one such condition seen in poorer classes, men of middle age who complain of pain in the foot and cramps in the calf-examination of the patient will show feeble pulsation in the vessels of the lower extremities, coldness of the limbs, occasionally sweating these being evidences of sympathetic disturbances. Women are not exempt and these patients are usually addicts to tobacco. The dorsum of the foot may be smooth and glazed blisters may be seen. The nails may become thickened and brittle. The condition should be spotted at this stage as the condition is amenable to treatment. Later when gangrene supervenes treatment becomes less efficient. Treatment consists in keeping this part warm by baths, stockings, use of Vasodilater drugs like 'Priscol' and graduated exercises. Surgical treatment consists in crushing of lateral popliteal nerves and lumber sympathectomy. After Lumbar sympathectomy patients must be made to do exercises to develop collateral circulation.

Similar symptoms may be seen in arterio-sclerosis seen in elders. In such cases sympathectomy gives no relief.

Varicose veins occurring in the lower extremity cause a fullness and throbbing and though pain is not felt causes intense discomfort, This symptom is not seen in advanced cases where the veins are enormously dilated and tortuous but in the early cases where veins have to be looked for, varicose ulcers may be seen in the dorsum of the foot. Treatment consists in graduated muscular exercises, use of elastic pressure bandages and veins if clearly seen may be injected with sclerosing fluids.

Another cause is Sudek's atrophy or Post traumatic osteodys-trophy-where after a trivial trauma the patient complains of pain in the foot. Clinically nothing is seen but radiographically intense decalcification of bones is seen. Treatment is by immobilisation in plaster for a few weeks and then graduated exercises. This condition can be prevented by proper rehabilitation of patients.

Injuries and infections of the foot demand special mention. All injuries of foot either on the plantar or dorsal aspect should be carefully treated. If cases are seen soon after injury and with a lesion of the skin a full thickness graft is immediately used. Full thickness grafts take well on fresh wounds. Large defects of skin on the plantar aspect and if recent a pedicle graft is preferable to an isolated full thickness graft. In dealing with infections of foot no incision should be made on the plantar aspect. They are as far as possible be made on one or the other side of the foot the sole of the foot being avoided. In heel abscesses the approach should be from either side and not on the heel.

Diabetes is so common that it must be thought of as a cause of foot pain in every individual after middle age, however glaring other causes may be. The pain may be due to peripheral nouritis or due to ulceration or painful corns. A note about care of the foot in diabetes may not be out of place. The foot should be kept scrupulously clean. The foot should be soaked in a light soap solution for 15 minutes, then removed, washed and dried. Then 70% alcohol is applied with a view to harden the skin and dusting powder applied. At no time should these patients be allowed to move out without foot wear for should these patients have an injury it very often becomes one of large proportions partly due to the diabetes and partly due to the coincident arterioselosis.

As soon as an injury occurs it should be cleaned and covered with a sterile dressing. Insulin and Vitamin B should be administered so that the patient may be kept sugar free. Hansen infections should keep their feet clean and protected as Diabetes.

I have tried to give a few of the common causes of foot pain. This is an everyday problem.

(Concluded)

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MANAGEMENT OF DIABETES MELLITUS

by

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DIABETES mellitus is quite a common disease even in India, in spite of the high proportion of cases going undetected due to paucity and reticence in patients reporting to the Doctor. Diabetes requires strict supervision and creates many problems special, social and otherwise and complications involve most of the systems of the body.

Osler's dictum " Know syphilis......and all other things clinical will be added unto you ", fortunately is going out of vogue after the advent of penicillin and we have to think of metabolic and chemical pathologies and as such the dictum could be changed now to " Know Diabetes......". Perhaps in another few years even diabetes may recede and the motto may read " Know collagen diseases......".

A few words about the aetiology and biochemical changes in diabetes mellitus is quite in place in the discussion of its management. Diabetes is a disease of the disorder of Carbohydrate metabolism, primarily due to a deficiency of Insulin and secondary changes occur in other metabolisms like that of fat, proteins, water and electrolytes.

A hereditary diathesis, is a striking factor and so also a general high incidence in middle age. The earlier its onset the graver is the prognosis as in juvenile diabetes and the later it occurs it has a milder course. Males are more prone than women and fat people have a strange attraction for the disease.

The anterior pituitary has a definite place in the metabolic storm and the growth hormone or the diabetogenic hormone plays its role. It may act as Insulin resistor or affect the secretion of Insulin itself.

The β cells of the islets of Langerhan's in the pancreas are the secretors of Insulin as proved by Banting.

The high glucose level of diabetics is not a passive accumulation but is maintained to give enough glucose to the tissues in the absence of insulin. There is evidence that gluco-neo-genesis occurs from Proteins and from fat with ketones as an end product. There is also evidence to prove a disturbance in the purine-metabolism and that an alloxan like substance is produced. This fact is better illustrated in Steroid induced diabetes wherein there is an excessive excretion of Uric acid which has a structural similarity with alloxan.

The essential biochemical lesion is, that tissues like the Liver do not remove the sugar from the blood rapidly to prevent hyperglycaemia and this is due to an absolute or relative deficiency of Insulin. Insulin lowers the blood sugar by encouraging Carbohydrate assimilation and deposits glycogen in the body tissues. Thus, this disease is a simple failure of production of Insulin by the β cells and this fact is supported to some extent by histological evidence as that of haemochromatosis. But now there is growing evidence of *Insulin resistance* playing a part in the disease as it is proved that accidentally depancreotomised human beings by operative procedures require far less insulin to maintain than that of

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Lecture delivered at the Salem I. M. A. Meeting.

an even moderate diabetic. This resistance may be from the anterior pituitary and evidence is seen in the resistance exhibited by hormonal diabetes, or due to ACTH or cortisone excess as happens in Cushings Syndrome. In steroid therapy, there is increase in glucogenesis and neo-glucogenesis by action of the gluco corticoids. We see the opposite of this in ablative lesions of the adrenals or the anterior pituitary as in Addissons or the Simmonds diseases (Sheehan's Syndrome) where there is an absence of glucogenesis and hence a great sensitivity to Insulin.

Recently the antagonistic action of the α cells of the islets have been described and the action of oral antidiabetic drugs is supposed to have some say in them.

Thus summing up, failure to produce Insulin, Resistance to Insulin and excessive gluconeogenesis form the basis of the disease.

The glycosuria of the disease naturally results in polyuria to carry off the glucose in the urine, and a consequent dehydration. Since Carbohydrate metabolism is low, fat is broken down into Aceto-Acetic Acid more than what the tissues oxidise normally. This fast abnormal katabolism of fat increases the ketones in the blood resulting in ketosis and appearance of ketones in the urine.

The normal neutralisation of acids in the urine by ammonia from the kidneys is not adequate as the acidity is high and sodium from the plasma is called upon to share the work which results in the fall of the CO_2 combining power of the blood, thus reaching acidosis, coma and death eventually.

Liver is usually fatty in diabetics and there is an excess of lecithin and cholesterol in the blood (Lipaomia).

Again the lack of Carbohydrate metabolism and the excessive loss of glucose in the urine leads to neo-glucogenesis from the body proteins and thus the protein katabolism results in wasting of the tissues with concurrent loss of weight.

A moderate case with polyuria, glycosuria, polydypsia, loss of weight, pruritus, polyphasia, failing vision, recurrent boils, ammennorhoea in females and impotence, a dry large tongue, loose skin, and other complications shout the diagnosis at the Doctor.

For routine diagnosis blood sugar estimation is superfluous. It is required only in the borderline cases with little or no symptoms, in doubtful young diabetics to exclude Renal glycosuria and in the institution of the present oral medication but is of *prime importance in the treatment of ketosis and coma.* Glycosuria in young people calls for a wide investigation to exclude emotional, cereberal and endocrine causes which account for about 10%, lag storage glycosuria and the most important Renal leak or Renal Glycousira.

A passing reference to the complications one meets with, is useful for their management.

Ketosis and Coma as well as the precomatose stages are always antedated by a history of neglect of Insulin, neglect of diet, carbuncles or other infections, vomiting from some cause, apart from sweet breath, thirst, *abdominal pain* and cramps.

Atheroma is natural from the lipaemic stage of the blood and is most manifest among the coronary, cerebral and renal vessels and equally so in the arteries of the legs. This last affection often leads to dry gangrene of the foot.

Infections are common with sugar loving organisms and carbuncles and

urinary infections are the rule, closely followed by pulmonary tuberculosis.

Renal failure from intercapillary glomerulosclerosis with heavy protein-uria, oedema and hypertension occurs. (Kimmelsteil Wilson Syndrome).

Neuropathy is most common and is very troublesome. It is a nutritional polyneuropathy. It is often very painful with painful muscles or meralgia parasthesia, or even painful joints. These *conditions are refractory to treatment.*

Retinopathy and ocular disorders : Diabetic cataract is precocious in nature and changes in the refractive errors are due to changes in the viscosity of the aquous humour. The retinopathy proper is well seen with an opthalmoscope and shows haemorrhages both in the arterial and venous sides (called aneurysms) and waxy exudates. These according to some are not preventible.

Obstetric accidents : Large babies and still births are common and the diagnosis of diabetes is often made on the birth of an unusually large baby.

MANAGEMENT

The aim is to control the biochemical lesion, maintain the standard weight and to prevent complications. This requires complete co-operation, the patient having been told of the disease is given reassurance and hope.

The most important factor is *diet* and this is designed to be pleasant, and adequate, in calories and to maintain the standard weight. It has to prevent glycosuria and thus dehydration. The quantity of Carbohydrates for sedentary people could be from 150 G to 200 G and for obese patients this is reduced further. The protein should be ample and about 11% of total worked out calories have to be from proteins. The fats are to be adjusted to make up the rest of the calories.

Thus whether one takes wheat or rice is immaterial as both are starches and the only reason to change to wheat being that the quantity consumed is less. It is rather easy to write out a mixed diet rather a vegetarian one.

There are some debated points in diet. Joslin gives a diet to keep the individual just below his standard weight and he gives about 1600 C - Rabinovitch gives a high Carbohydrate diet and opines that incidence of T. P. and atheroma is less in his cases and Himsworth's work support his contention. Lichenstein allows his patients a free diet and Insulin to cover it to the extent of slight glycosuria. He gives 6 G of Carbohydrate, 2 G of proteins and 2·5 G of fat per KG. of body weight and the calorific value for children 90 – 70 (for ages 0 – 5 – 10) and 50 for over ten years per KG of body weight. Tolstoi controls his patients clinically rather than chemically. But Dunlop is emphatic that free diet is harmful and leads to more complications. A via media can be struck between these two extremes to get results medically, to satisfy the taste of the patients, as we find too often the monotony in food drives them to a free diet with no control.

INSULIN

The famous discovery of Banting and Best revolutionised the treatment of diabetes and opened new vistas to the practitioner. The P. Z. S. or Protamine Zinc Insulin which are long acting was an improvement and the globin insulin followed with less allergic reaction. The Lente Types came later and has been found to be very satisfactory. If a long acting insulin is given the Carbohydrates have to be distributed in many meals. An intake of 250 G may be advantageously distributed thus : Breakfast 50 G, 10 O'clock 25 G, Lunch 50 G, Tea 35 G.s Supper 50 G and night cap 40 G. This may be inconvenient to some people and they can be given even two large meals

preceded by soluble insulin and two light meals without insulin.

The *N. P. H. Insulin* contains a judicious proportion of soluble and long acting insulins and more exact control is possible.

The *globin insulin* can be given to allergic diathesis and acts well on brittle diabetics who tend to oscillate from thirst to hypoglycaemia in 24 hours.

The *Lente Insulins* have most of the aforesaid advantages and has the least allergic action.

But before proceeding to Insulin therapy the dictum should be

(i) *Over weight diabetics-No Insulin* till the body weight is reduced to the optimum

(ii) *All under weight diabetics receive Insulin*

(iii) *All Juvenile diabetics receive Insulin from the start.*

An emaciated diabetic should get *enough carbohydrates to abolish ketosis, enough calories to restore body weight and enough Insulin to reduce or abolish glycosuria. Control* of Insulin therapy is best by urine examination for sugar rather than by estimation of blood sugar.

The aim of therapy is to stop excessive fat katabolism and thus dehydration, spare the use of proteins for neoglucogenesis and thus prevent wasting of tissues. Control of hypoglycaemia is only a secondary aim.

Soluble Insulin action starts in 3 hours and is over by 6 hours and this is most useful in (*a*) stabilising a diabetic, (*b*) for emergencies like ketosis, coma infections and operations, and (*c*) for fluctuant diabetics especially in children.

Depot Insulins I. Z. S. (Lentes) amorphous. crystalline or mixture i.e., semi lente, ultra lente or lente type of insulin act for 10–15 hours, 24 to 36 hours, and 18–24 hours respectively. They have least reactions. A moderately severe case can be controlled by a single injection of 20–40 units of I. Z. S. If higher doses than 60 units per day are needed, zinc protamine and soluble insulins are better and less risky. I. Z. S. is replacing now most of the depot insulins slowly.

Z. P. Insulin (Zinc Protamine) has maximum effect in 10 hours. Glycosuria can occur in the forenoon. It is dangerous to raise the dose of Z. P., Insulin to overcome the glycosuria as it may produce hypoglycaemia at night. The dose of Z.P. Insulin should normally be not more than 80 units per day.

A note of warning with Insulin therapy is that adequate asepsis should be assured in the daily and more frequent injections as diabetics are prone to get infections quickly and react badly to the same. If possible such methods should be taught to the patient or the attendant to obviate the constant daily attendance of a doctor.

The symptoms of hypoglycaemia should be explained to the patient as prompt awareness can reverse this reaction. Hypoglycaemia rarely kills. Hunger, sweating, tachycardia, tremor, faintness, mental confusion, twitchings, coma and convulsions are the order of procedure, the earlier reaction are adrenal and the latter due to cereberal glucose depletion. (*In short this produces a wet anxious man*) Glucose orally and rarely by the I. V route completely reverses the symptoms and Adrenaline I. M is an antidote. The symptoms after depot insulins are less dramatic - headache, malaise, night sweats, nausea, confusion, drowsiness and sometimes coma occur. The common causes of hypoglycaemia are *unpunctual meals* and of not carrying lumps of sugar

as a preventive measure. The dosage of insulin after such attacks should be reduced by 4 units.

One should be able to differentiate the hypoglycaemic attack from ketotic coma. The *picture of Ketosis* is a history of not taking insulin, an infection, *ill health,* glycosuria *dehydration, dry skin* and tongue, weak pulse, low B. P. air hunger, dimished reflexes. and urine shows ketones and blood hyperglycaemia and lowered Co2 combining power.

In short he is a Dry, Drowsy, Dehydrated, ill man.

Examination of Urine is important in Insulin therapy. The Doctor or the patient should examine the urine daily if not more often for sugar and ketones. The simple Benedicts test for glucose or even the clini test is good enough. But for acetone Rothera is the best and there is a simple modification of it for the sake of the patient. Darling has made a powder from Ammonium Sulphate 87% anhydrous tribasic sodium phosphate 12·5% and sodium nitroprusside 0·5% which is kept dry and lasts long. To a small pinch of this powder few drops of urine is added and the colour change to purple pink if seen in 3 minutes shows prescence of ketones. This test if frequently done, prevents coma cases coming to the Hospital. *To maintain a ketone free urine is of prime importance in Diabetes.*

A word about *oral medication* of diabetes has to be given here. The time is too short to pass any definite opinion on them but it is a welcome change if it proves good and brings relief to the pincushion of a diabetic. Unfortunately these drugs are not yet indicated for juvenile diabetics or the severer forms of the disease and *it has no place* in the treatment of ketosis, coma or other complications. The first drug to reach us was BZ 55 or carbutamide sold in the market under the proprietory name of 'Nadisan'. The first reactions to this drug are (*a*) It can never replace insulin (*b*) It has hypoglycaemic action, (*c*) It has a place in the treatment of diabetes, (*d*) It acts well in recent mild or obese diabetics, (*e*) Control by diet is essential, (*f*) Toxicity is low but appreciable–Liver damage, Agranulocytosis and purpura can occur after prolonged medication. (*g*) It cannot be used without blood sugar control, (*h*) *It is of no use in emergencies.*

The dosage of Nadisan is given under:-

First day 3 in the afternoon after meals and two at night after meals.

2nd and 3rd day 2 twice a day as before

4th and 5th day two in the after-noon and one at night and subsequently two once a day or less as indicated by the Urine.

More recently a new drug Tolbutamide has come into the field. It is not a sulphanilamide product unlike carbutamides. They are being marketed as Tolbutamide, Rastinon, Artosin etc. It is found to be as effective as Carbutamide and less Toxic. But even here allergy, leukopaeria, Thrombocytopenia and an occasional agranulocytosis reaction have been reported. Periodical check up is necessary. The indication of this drug are similar to that of Nadisan outlined above and the dosage is similar. If by any choice there is discontinuance it has to be restarted as per schedule again. Hypoglycaemic symptoms occur from 3rd to 5th day and the patient can be advised about the same.

Generally speaking the oral anti diabetic drugs are welcome but cannot replace Insulin. Their action seems to be partly by interference with the liver enzymes and also by direct action on the

'L' cells of the islets of pancreas which cells are considered to be antagonistic to the 'β' cells producing Insulin. It has also come to the notice that unless there is some pancreatic tissue producing Insulin these drugs have no action by themselves. They have no action on the metabolism. They encourage Insulin secretion and protect them from adverse factors. It is also known now that we can use these drugs along with Insulin and one has to be cautious when stopping Insulin and changing over to Tolbutamide or Carbutamide as sudden hyperglycaemia can occur. The drugs have an all or none action and so abnormal increase of dose does not help.

Dunlop advocates their use in Diabetes over 40 who have no tendency to ketosis whose daily Insulin requirement are less than 40 units and whose fasting blood sugar is less than 300 mg. %. In obese diabetics one has to be cautious since introduction of these drugs may perpetuate or increase the obesity with its attendant evils. There is a great danger of misuse of this drug by the patient himself and producing all complications inclusive of liver necrosis.

From personal experience after extensive use I am hesitant to use these indicriminatively. A complete prior assessment of the stage of the disease, the presence or otherwise of complications is a *must* before instituting these drugs. Of these I prefer Tolbutamide being less Toxic. A few instances of precordial pain has occurred after the use of Nadisan which has been relieved on the cessation of the drug. I have also found that in some cases carbutamide controls better the glycosuria than Tolbutamide and vice versa. And thus an individual study is indicated. I do not give the oral drugs in young and in very severe diabetics and have tried a combination of Insulins and oral drugs in the latter type to some extent. Brittle and fluctuant types are not to be given these drugs. The type I prefer is the middle aged, non emaciated mild diabetic with no complications. In short the oral drugs cannot yet replace, Insulin in most cases and are contra indicated in some types, and are of no use in emergencies and complications. Nor do they prevent the march of the disease to any great extent but does make the patient complacent and satisfied.

Management of Complications: At the outset every diabetic must be examined with special reference to C. V. system for coronary diseases, hypertension, peripheral vascular disease the C. N. S. for neuropathy, the eyes for cataract and retinopathy and skiagram to exclude P. T. *Any unexplained changes in weight or increase in Insulin* should be viewed with suspicion.

Diabetic Coma: This is a medical emergency and all speed is indicated and we should combat (*a*) ketosis with Insulin (soluble), (*b*) Dehydration and sodium depletion with normal saline infusion, (*c*) Infection by antibiotics and (*d*) vomiting by gastric lavage.

Tissues are insulin resistant and demand high doses. 50—100 units to start with, a quarter to half of which is given by the I-V. route. An average case may require 250 units or more in 24 hours. Normal saline 1 or 2 pints is a safe amount. Treatment is to be controlled by blood sugar levels and acetone in freshly catheterised urine and the CO_2 coming power of blood. The *Urine Sugar is unreliable.* The stomach is washed with weak sodabicarb solution and *Penicillin* is given in high doses. When consciousness returns oral glucose 25 G with an Insulin cover is given.

With Insulin therapy glucose passes into the tissues and takes 'K' (Potassium) with it, leading to fatal paralysis

or anuria. K salts like Potcitras 2 G four hourly is to be given orally on return consciousness. Prognosis is good with early diagnosis and adequate treatment.

Atheroma : With its attendant coronary or cerebral thrombosis or peripheral vascular disease is preventable with adequate control of diabetes. The treatment of the first two is specialised and the last surgical and cannot be dealt with here.

In prevention of gangrene, the diabetics with poor peripheral circulation is to be advised not to put hot water bottle on their feet and never to cut their own corns or nails and keep their feet as clean as their 'face!' Well fitting shoes is a *must* for them.

Skin infections are prevented by cleanliness and *early* detection of P. T is important and any loss of weight in a diabetic otherwise controlled should have his chest X-Rayed.

Urinary infections seldom occur in controlled cases but Kimmel Steil Wilson Syndrome with massive albuminuria oedoma and hypertension occur and is a major hazard in juveniles.

Diabetic neuropathy is seen mostly in neglected diabetics and may be associated with loss of weight, hepatomegally and retinits. It is often a painful condition and may be assymmetrical. There may be ataxia, impotence and atony of bladder. This neuritis may be toxic or metabolic in origin. There may be signs of avitaminosis also like stomatitis and pellagrous skin.

Treatment is prophylaxis by controlling diabetes and exhibition of Berin and B Complex group of drugs. *Once it has set in* high doses of Macrabin 500 to 1000 μg., UV., Rays, shortwave therapy, Pyridoxine in high doses may help but in many fail miserably. It is indeed pathetic and pain has to be controlled by analgesics like Irgapyrin, novalgin, or Buta-Zolidines.

Ocular complications of a transitory nature occur soon after institution of Insulin therapy from changes in water and mineral metabolism and thus in the aqueous humour of eye. The diabetic cataract is not a great problem and the retinopathy is not completely preventable except by adequate control of diabetes, and its aetiology is still not known.

Pregnancy and diabetes: Controlled diabetic women have normal fertility but are liable to get complications in pregnancy. Increased abortions. miscarriages and still births occur. There is a tendency to produce large babies. Cicely Williams says that Serum gonado-tropin level goes up and this may be the cause of complications and could be prevented by Progestin and oestrin. Diabetic mothers get worse up to the Sixth month and then improve probably due to the action of the foetal pancreas.

In general prevention, the hereditary factor is to be taken seriously in marriages. Again there will be less diabetics if there are less fat people and complications can be avoided by good medical practice and good patient doctor relationship.

PROBABLE AETIOLOGY OF TROPICAL EOSINOPHILIA

by

Dr. M. A. ABDULLA, M.B., B.S., T.D.D.,

Civil Assistant Surgeon, H. Qrs. Hospital, Kozhikode.

Tropical eosinophilia is a distinct clinical entity. Adolescents and young adults are generally the victims. Malaise, general weakness, evening temperature, loss of appetite, breathlessness on exertion, sometimes even at rest, occasional spitting of blood and cough are the main symptoms. Clinically marked sweating, wheezing, rales and rhonchi scattered all over both lung fields are noticed. Examination of blood for total and differential count reveal a marked high total count and high differential eosinophil count. As eosinophil count shows an increase in various conditions an absolute circulating eosinophil count of 2,000 per c. m. m. and above is generally considered typical of Tropical Eosinophilia, provided the total count also is increased. Fluroscopic examination reveal marked haziness, sometimes ground glass like appearance with marked inspiratory exertion. Xray chest in most cases reveal fine wooly mottling scattered all over both lung fields mainly towards the hilar area, the extreme periphery being fairly clear. The Xray appearance and blood picture are fairly uniform in all cases. Hence these two factors are considered essential for the diagnosis of tropical eosinophilia.

Various theories and speculations are put forth regarding the aetiology of this condition. One of the main theory is the invisible virus theory. Some unknown yet to be isolated virus is considered the responsible agent. Fairly sharp onset of the illness affecting chiefly the whole of the respiratory mechanism, probably resembling the virus pneumonia may be the cause of this theory. Second theory is the allergic theory. Symptomatically it is akin to bronchial asthma which is an allergic disease. But in this case no allergen was so far isolated and anti-allergic treatment is very slow in its action unlike bronchial asthma. The characteristic blood picture in allergic disease is widely different from that of the blood picture in tropical eosinophilia. Third speculation is regarding humidity and climate. This disease is fairly common in the damp climates of the tropics. In dry climates of the tropics, it is much less common. Most of the attacks are seasonal and precipitated during change of climate from dry to humid. Hence this speculation has come into vogue.

Tropical eosinophilia as seen in West Coast

(*a*) **Age Group** :— This disease is commonly seen in two sects of people in the west coast. The first in the adolescent group. In this, the usual age is between 8 and 14. The second and the most important group is the young adult group. The average age limit of this group is between 18 and 30. The average ratio between the 1st and 2nd group is roughly 7 : 9. Typical tropical eosinophilia is not seen in people passed the age of 35. The disease is occasionally seen in children below the age of eight also. In the adolescent group, both sexes are equally affected. In the adult group, males pre-dominate.

(*b*) **Blood count** :—Though typical blood picture is seen in both groups, there is little difference noticed between

the two groups. The total W.B.C. count and the absolute eosinophil count are more in the younger age group. The younger the child generally the higer the count. Average blood picture in the adolescent group is total count 15–20 thousand and differential count (eosinophil) 60–75%. In the adult group, the average blood picture is total count 12-16 thousand; differential count 40–60%. It is observed that the higher the age the lower the count.

(*c*) **Erythrocyte sedimentation rate** was not uniformly done in all cases. From the cases, where it has been done, it has been found uniformly high.

(*d*) **Xray appearances**:—Xray examination was done in majority of cases. The characteristic picture namely fine mottling over both lung fields more marked towards the hilum, the extreme periphery comparatively free was seen in 80% of cases Xrayed.

(*e*) **Main symptoms**:—Malaise, weakness, temperature especially in the afternoon, cough, breathlessness—sometimes even at rest, orthopnea, loss of appetite occasional spitting of blood are the chief symptoms complained off. Loss of appetite and malaise are the starting symptoms in very many cases. In a few cases, cough and spitting of blood were the first symptoms noticed. Breathlessness, temperature and orthopnea developed subsequently and in all cases. Clinical examination of chest revealed increase in respiratory rate, expiration slightly prolonged, rales and rhonchi scattered all over both lung fields. Examination of other systems revealed no abnormality.

(*f*) As far as treatment of this condition was concerned, marked response and immediate relief to symptoms was uniformly afforded by arsenic injections. The preparation in common use is Acetyl arsan. Bi-weekly injections for three weeks are given followed up by oral arsenic, if necessary. Vitamin C is given uniformly in almost all cases along with arsenic. Only 5% of the cases required other medicines like aminophylline and adrenaline for immediate relief of asthamatic symptoms. With the arsenical treatment alone the average patient is free from symptoms within a week of starting the injections. The relief offered was quicker if the severity of symptoms were high. Toxicity of arsenic like encephalitis and dematitis stands as a sound barrier against the free use of this drug. But the relief offered by the drug is so prompt and the toxicity of arsenic is so rare that arsenic still holds the field and considered *the line of treatment.* Prolonged symptomatic treatment with drugs like Aminophylline, Ephidrine etc. may also improve the condition. But in these cases, the patient was to suffer for a long period and the result is quite uncertain. In a few cases, where the severity of symptoms were less and no treatment undertaken, the symptoms slowly subsided probably as he was getting acclimatised to the new climate. Though arsenical treatment gives prompt relief of symptoms, the blood picture and X-ray appearance returned to normal only slowly taking on the average about 2–3 months. Even at the end of three months, the differential eosinophil count was seen to be little high, 8–15% on the average, though the X-ray appearance and the total count is normal.

While I was working in the T. B. Sanatorium, Thambaram, two years ago, while taking down case histories, a few patients used to give the history that they were victims of tropical eosinophilia before. Most of them had arsenical treatment with prompt relief. Few cases had regular seasonal attacks. All those cases who gave this particular history were suffering from tuberculosis and hence admitted in the sanatorium. This made me think at that time whether this particular history has any bearing on the present condition of the patient, namely pulmonary tuberculosis. But at that

time. I did not get any opportunity to study the question any further. Another interesting thing I observed there in these patients was that their disease was comparatively minimal and responded very quickly to anti-tubercular treatment. Next chance I got to study this problem in a little more detail was soon after the influenza epidemic of 1957. These observations are made on the patients of West Coast chiefly central Malabar. My attention was drawn to the subject again when a patient of mine whom I have twice previously treated for tropical eosinophilia reported sick. He said he was laid up with flue, for the last 10 days. As he was recovering slightly he got sudden temperature, cough and dyspnea. The temperature was obvious in the evenings. When I examined him he had 102°F temperature. Examination of chest revealed cavernous breathing right apical and mid-zone with crepitutions. Rest of the lung fields were clear. An X-ray was taken and sputum examined. X-ray showed two distinct cavities with surrounding infiltration in the right apical and mid-zone. Sputum was double positive for AFB. He was put on streptomycin and I. N. H. and rest. He responded very well to this line of treatment. After two months, when I examined him, his chest was clear clinically, though the treatment continued. At the end of treatment (in 3 months hence) when an X-ray was taken, it was absolutely normal. Sputum was negative. E. S. R. only 6 m. m. first hour. This case of mine gave me an impetus to observe more in this line. As the epidemic of influenza was subsiding, I used to get many cases of persistant evening fever and cough which an investigation proved to be pulmonary tuberculosis. Of these cases (nearly 30 I observed), ten cases gave definite history of tropical eosinophilia before and they had treatment with arsenic, several times with good relief. All these ten cases except one respond very well to anti-tubercular treatment. The one which has not responded satisfactorily had ambulant treatment only. The cases which responded showed complete clearing of Xray lesions with remarkable clinical improvement. The case histories of these ten cases clearly showed that the tuberculosis was precipitated by the influenza attack. Going more into the detailed previous history it is gathered that even before getting their eosinophilia attack there used to be some factors which lowered their general resistance, like continuous travel, sleeplessness, over-exertion, mental worries etc. But this time when the general resistance was very poor due to severe attack of influenza, they were attacked by pulmonary tuberculosis.

From the above observations, the following suggestions are made regarding the aetiology of tropical eosinophilia.

(1) Tropical Eosinophilia is only one of the manifestations of pulmonary tuberculosis. People of good resistance who are harbouring moderate doses of tubercle Bacilli in their body without producing the disease, when their general resistance is slightly lowered they become the victims of the disease called Tropical Eosinophilia. In the same people, when their general resistance is suddenly lowered they become the victims of the parent disease, namely Pulmonary Tuberculosis. Tropical Eosinophilia is in the nature of an allergic disease, or it is the result of the tuberculotoxins circulating in the body of one whose resistance is fairly high. When the general resistance is slightly lowered, the harbouring tubercle bacilli try to come up and produce the disease. But the resistance is not so low as to allow this to happen. Some toxins (tuberculotoxins) are produced in the system. Body resistance tries to dispose of this foreign material from the system. In this struggle, some reactions take place which result in the production of the disease called Tropical Eosinophilia. When the tubercle bacilli

try to come up if the resistance is poor, it naturally results in the production of the disease called Pulmonary tuberculosis and when the resistance is fairly good, it results in the production of the disease called Tropical Eosinophilia. Repeated attacks of Eosinophilia become possible in a man who harbours fairly good dose of tubercle bacilli and whose general resistance is fairly good when he is subjected to repeated slight reduction in his general resistance.

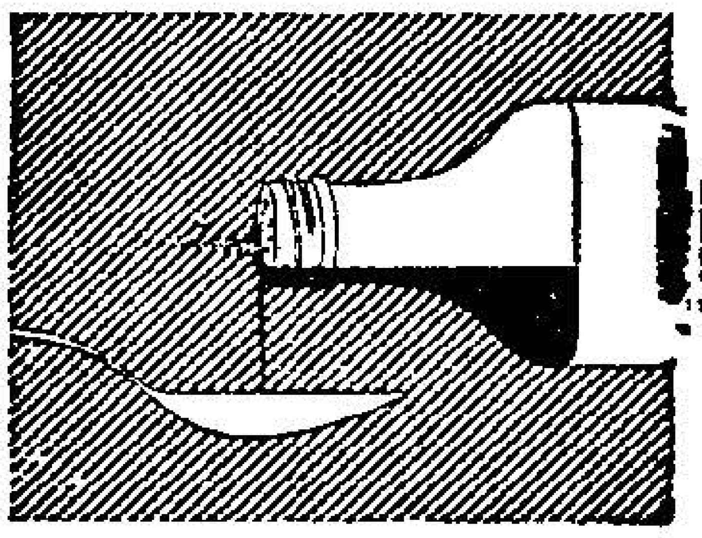
From these observations and suggestions I conclude that Tropical Eosinophilia is only a manifestation of Pulmonary tuberculosis in a healthy individual whose general resistance is temporarily lowered slightly. It is in the nature of a toxic reaction of the healthy body to the tuberculotoxins. Tropical Eosinophilia patients, if their general resistance goes down suddenly and heavily, become a prey to the parent disease, namely pulmonary tuberculosis.

Summary.

The present conception of Tropical Eosinophilia is briefly described. Theories regarding its aetiology are mentioned. Few common observations made in West Coast of Tropical Eosinophilia patients described. Particular observation of debilitating illness on Tropical Eosinophilia cases dealt with. Impressions gathered from the observations were analysed and it is concluded that Tropical Eosinophilia is only a manifestation of Pulmonary Tuberculosis.

TRACE METALS
for EFFECTIVE TREATMENT
OF HYPOCHROMIC ANAEMIA

COBAFERON
'CIPLA'



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INDIAN MEDICAL ASSOCIATION,
MADRAS STATE BRANCH.

Minutes of the Meeting of the Council of the Madras State Branch of the Indian Medical Association, held at the Rest House of the Salem District Co-operative Central Bank Ltd., Cherry Road, Salem. on Saturday the 29th March 1958 at 11 A.M.

20 MEMBERS WERE PRESENT.
DR. M. SANTHOSHAM PRESIDED.

24 members have sent messages expressing their inability to attend the State Council Meeting.

Resolution condoling the death of Dr. H. J. Masilamani of Madurai was moved from the Chair and passed unanimously, all the members standing for a minute.

The minutes of the previous Council Meeting held at Coimbatore on 23rd November 1957, as printed and circulated to all members, were adopted.

The 12th General Assembly of the World Medical Association to be held in Copenhagen, Denmark, in August 1958—election of delegates of I.M.A–letter from the Central Office :

The circular of the Central Office inviting nominations, if any, of members of I.M.A. who may be willing to attend the 12th General Assembly of the World Medical Association to be held in Copenhagen, Denmark, in August 1958, was placed by the Hony. Secretary before the Council. The nominated members have according to the circular. to bear by themselves the travelling and other expenses. The Council recorded the communication in view of the fact that the local branches who were informed of the matter have not sent in any recommendations.

Medical Benefit Council of the ESI Corporation – representatives from the I.M.A. – selection of-proposals-letter of Central Office :

The Hony. Secretary placed before the House a circular received from the Central Office calling for proposals of two names for selection of representatives of I.M.A. to the Medical Benefit Council of the Employees' State Insurance Corporation as the term of office of the present two representatives namely Dr. (Mrs.) B. Thungamma of Banaras and Dr. C. S. Thakar of Bombay expires on 5th April 1958. The Council after considering the circular and consulting the House, decided to nominate Dr. Y. P. Vasudevan M.B.B.S., B.S.SC.. of Coimbatore, the immediate past President of the State Branch, for one of the two vacancies and desired the Hony. Secretary to communicate the same to the Central Office.

The Indian Nursing Council-selection of a representative from I.M.A.—proposals—letter from Central Office:

The Hony. Secretary informed the House that the term of the Indian Nursing Council has expired, that the Council is to be reconstituted and that the IMA which is entitled to have a representative on the Council has to elect its representative now. He placed before the Council the circular of the

Central Office in this regard which called for proposals from the State Branches to fill up the vacancy which is now held by Dr. Chamanlal Mehta of Bombay. The Council after considering the circular and in consultation with the members present decided to nominate Dr. Y. P. Vasudevan of Coimbatore, the immediate past President of the State Branch, for consideration of the Central Office in electing its representative on the Indian Nursing Council, and desired the Hony. Secretary to communicate this decision to Central Office.

The Second World Conference on Medical Education to be held in Chicago, USA, during August-September 1959—————names of possible Speakers from India-proposals-letter from Central Office:

The Hony. Secretary informed the House that a communication has been received from the Central Office calling for nominations of members of the State Branch who would like to speak during the Second World Conferenee on Medical Education scheduled to be held in Chicago, USA, from August 30th to September 4, 1958, under the auspices of the World Medical Association. The nominated speakers will have to bear their own charges for travel and other facilities, and the nominations were required to be sent by 25th February 1958. The Hony. Secretary informed that the Circular itself was received only on 10th February 1958 and there was hardly any time to circulate and contact the branches etc., In these circumstances and in view of the fact that the nominees will have to pay their own way to USA, the council felt the fact that there was no point in further considering the matter, and recorded the papers.

Employees ' State Insurance Corporation-choice of doctors by workers-resolutions passed by the Working Committee and Central Council-letter from Central Office:

The Hony. Secretary placed before the Council the circular and copies of the resolutions on the ESI Scheme received from the Central Office. The resolutions deal with the views on the proposal to extend the medical facilities to the family of the worker; the need to allow the worker to choose his own doctor; the need for adoption of Panel System: the need to reopen the decision of fixing the capitation fee and increase of the same to Rs. 6—8—0 for Bombay and Calcutta and Rs. 6/- for other places; the equitability of paying the Insurance Medical Practitioners for the period for which they have been removed from the doctors' lists, etc., While appreciating the efforts of the Central Council of I.M.A. in this regard, the Council recorded the paper.

The 126th Annual Meeting of the British Medical Association to be held in Birmingham in July 1958-appointment of a delegate of I.M.A.-proposals-letter from Central Office:

The Hony. Secretary placed before the House a circular received from the Central Office which called for proposals for consideration for the appointment of a delegate to attend the Annual Meeting of the British Medical Association to be held in Birmingham from 14th to 18th July 1958. The delegate will have to bear his own expenses in attending the meeting, as neither the BMA nor IMA will defray his expenses. The Council recorded the papers as no proposals were received from the local branches to whom a copy of the circular was sent.

Your Health-magazine published by the I.M.A.-enrolment of subscribers-letter from the Hony. Editor of the Journal of I.M.A.-consideration of:

The Hony. Secretary placed before the Council a letter of appeal received from Dr. P. K. Guha, the Editor of JIMA, Calcuta, regarding efforts to be taken by

all branches of I.M.A. as well as individual members to enrol at least one or two subscribers for the magazine YOUR HEALTH published by the Indian Medical Association, as the Association is publishing the magazine and it is but fair that the members extend their support for its improvement. The subscription for YOUR HEALTH is Rs. 8/- per annum or Rs. 12/- for 2 years. The Council considered the appeal, and decided that the Madras State Branch of I.M.A. may become a regular subscriber for the magazine, that the subcription may be sent for a period of two years at a time, and that the Hony. Secretary may issue circulars to all the local branches of I. M. A. under the jurisdiction of the State Branch to become subscribers to the magazine YOUR HEALTH likewise.

Vote of thanks.

Moved from the Chair, the following resolution was passed unanimously and the Hony. Secretary was authorised to communicate the same to the Hony. Secretary of the Salem Branch of I.M.A,

Resolution.

"This Council expresses its sincere thanks to the Salem Branch of the Indian Medical Association for the excellent arrangements made for the successful conduct of the meeting of the State Council of the Madras State Branch of I.M.A. and for the fine arrangements made for the boarding and lodging of the members of the Council attending the meeting".

The meeting terminated at 1–30 P. M.

(Sd.) M. Santosham,
President,

(Sd.) C. Arumugam,
Hony. Secretary.

ASSOCIATION NEWS

COIMBATORE BRANCH

A monthly meeting of the Association was held on 31-5-58 in the Association Premises. Dr. T. V. Sivanandam, MBBS. MLC., President, presided.

The nominations for the posts of the President and the Vice-Presidents for the Madras State Branch of Indian Medical Association for the year 1958—59, were held.

The President then welcomed Sri M. A. Manickavelu Naicker, Minister for Health, Government of Madras who was kind enough to attend the meeting.

The President then expressed that Coimbatore needs a Medical College. He also pointed out that the Medical Men in Government Services are paid very low and hence there is dearth of Medical Officers for the Government Service and the only solution for the same is by the way of increasing the remuneration and as regards teaching personnel, he expressed that medical men should be sent abroad for higher studies before they set up private practice.

Regarding the Honorary system, the work done by the Honorary Medical Officers was appreciated and he requested the Health Minister to extend the system wherever possible.

Regarding the Employees' State Insurance Scheme, he expressed that the Panel System was working well and felt sorry for having not extended the same to the other areas where the scheme was implemented recently.

Then the Health Minister Sri M. A. Manickavelu Naicker addressed the members. He expressed that the next choice for Medical College would be Coimbatore, which is an industrial town and is progressing very rapidly. The training of Medical Personnel for higher studies, the Government has decided to send medical men abroad, who had 10 years and more for retirement. The Director of Medical Services, who was asked to submit proposals has done so and these were under consideration.

Regarding the failure of extending the Panel System of Medical Service in the Employees' State Insurance Scheme, the Minister had expressed to go into the matter further. The Honourable Minister sincerely admitted that the emoluments of doctors are very low and should be increased and due to lack of finance, the Government was not able to carry out the desire to increase the emoluments and it is hoped that it would be done in due course and the Minister has also requested the Association to keep this issue alive by sending repeated reminders. Casually he pointed out that Foreign Medical Men, who had come to India had rendered medical help in a spirit of dedicated services.

Then Dr. (Mrs.) K. I. Vytilingam, Physician, Christian Mission Hospital, Vellore, spoke on " Management of Heart Diseases " and gave valuable information which could not be got from text books.

CHINGLEPUT BRANCH

The ordinary meeting of the Association was held on Saturday the 19th July 1958 at the Chingleput Venugopal Club, Chingleput.

Dr. S. Sundararaman M.S., addressed the members on "Endocrines in Surgery"

Condolence resolution on the demise of Dr. M. R. Guruswamy Mudaliar MRCP. was passed.

Election of President & Vice-Presidents (For I M A Centre.) was held.

ERODE BRANCH

A meeting of the Association was held in Erode Medical Association Library Hall on 31st May, '58 with Dr. T. S. Bhaskaran in the Chair. Dr. K. A. Krishnamurthy, M.D., M.R.C.P. (Edin); F.R.F.P.S., Lecturer in Paidiatrics, Madurai Medical College, Madurai, spoke on "Diagnosis and Management of Tubercular Meningitis in Children".

NILGIRI BRANCH

A special meeting of the Association was held on Saturday the 21—6—1958 at the Military Hospital, Wellington. Dr. R.V. Rajam, M.S., F.R.C.P. (Edin.), F.R.S., (Edin.) Director, Institute of Venereology, Govt. General Hospital, Madras delivered a lecture on the "Present Status of Venereal Diseases."

RAMNAD BRANCH

An ordinary meeting of the Ramnad District Branch I. M. A. was held on 13—7—58 at 5 p.m. in the premises of Kamak Hall, S. H. N. V. High School, Sivakasi. Dr. Raju Iyer presided over the meeting. Dr. K. A. Kalyanam, F.R.C.S., D.M.R., spoke on "The problem of surgical pain". Election of One President and three Vice-Presidents to the Central I.M.A. was also held.

SOUTH ARCOT BRANCH

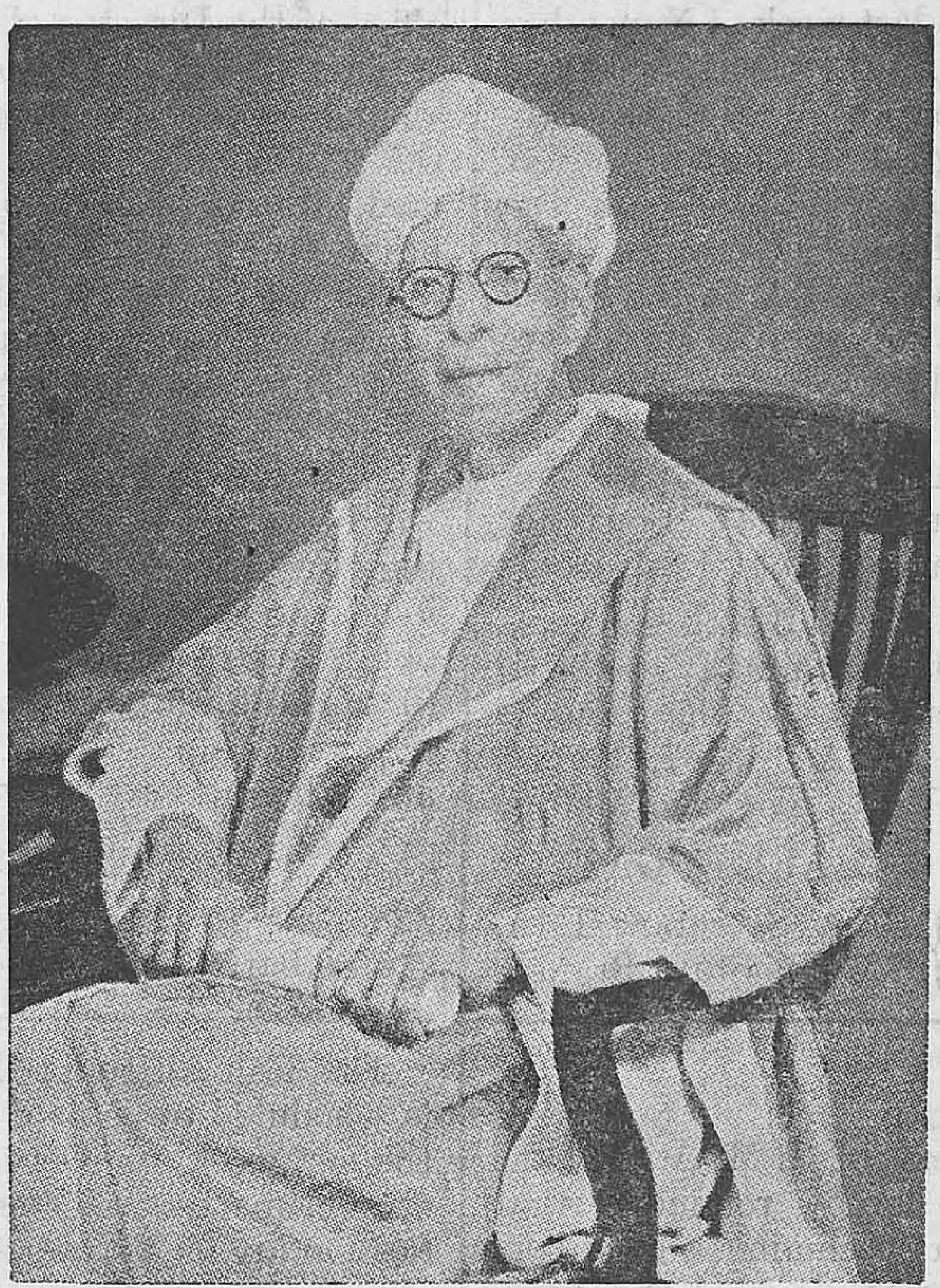
The General Body Meeting of the Association was held on Saturday the 14th June 1958, in the Government Head Quarters Hospital premises, Cuddalore. Dr. B. Veda, MBBS., A.D.M.O., Cuddalore gave a talk on "The Management of Common Fevers".

TIRUCHY BRANCH

A monthly meeting of the association was held on Saturday the 19th July 1958 in the Association premises. Dr. L. S. Ramachandran the President presided. A condolence resolution condoling the death of Dr. M. R. Guruswamy Mudaliar was passed all members standing in silence for 2 minutes. The Election of One President and Three Vice-Presidents for the Central Office for the year 58-59 was held.

Dr. A. L. Annamalai, MBBS., DTM & H, MRCP., Physician, Govt. General Hospital Madras delivered a talk on "Diagnosis and Treatment of Bronchial Asthma".

THE LATE Dr. M. R. GURUSWAMI MUDALIAR



1880 — 1958

"Dr. Guruswami Mudaliar's death has created a void in the medical profession that can never be filled adequately. His remarkable personality and his enthusiasm for the cause of suffering humanity, particularly the poor, had always endeared him to all classes of people. As a teacher, he was outstanding and many are his pupils spread all over India who will regret his demise. He was a staunch fighter for the rights of the Indian doctors and if all that he has done during his service in the State are revealed, it will be realized how strongly he stood for the rights of the Indian doctors against powerful members of the Indian Medical Service of foreign domination."

—Dr. A. Lakshmanaswami Mudaliar.

We offer our heartfelt condolences to the bereaved members of his family.

ANNOUNCEMENTS

The 13th Madras State Medical Conference, 1958, will be held in the City of Madras during the last week of November 1958. There will be the usual Scientific Session and Exhibition of Medical Products and Surgical Appliances. A Souvenir will also be published on the occasion. The Hony. Secretaries of all the local branches of I.M.A. in the State, and all members of the I. M. A. are requested to kindly co-operate with the organisers of the Conference and make the Conference a grand success. Further particulars regarding the Souvenir, Exhibition etc., may be obtained from:

"Dr. B. Rama Rau, B.Sc., M.B.,B.S., Dr. Ramachandramurthy, L.M.P., Hony. Secretaries of the Madras City Branch, I.M.A. 155-57, Poonamalle High Road, Kilpauk, Madras -10".

C. ARUMUGAM,

328, Raja Street, Coimbatore. | Hony. Secretary, IMA. Madras State Branch.

All the members of I. M. A. Madras State Branch are hereby reminded that facilities exist for becoming subscribers to the British Medical Journal at concession rate of Rupees (28/25) Twenty eight and twenty five naye paise per annum which works out to one half of the published price of the journal. Intending subscribers and those members whose subscription has recently expired are informed that they may remit the subscription of Rs. 28/25 nP. BY MONEY ORDER to the undersigned, on receipt of which necessary action will be taken. Cheques drawn for Rs. 28/25 ON ANY OF THE BANKS SITUATED AT COIMBATORE will be accepted at par; but cheques drawn on outside banks should include a sum of 75 nP towards bank charges.

C. ARUMUGAM,

328, Raja Street, Coimbatore. | Hony. Secretary, IMA Madras State Branch.

Copies of the 12th issue of the Medical Bulletin have just been received from the office of the Director of Medical Services, Madras, and are available for distribution among the members and non-members of the I M.A. for cost. Members of the medical profession who are desirous of having the same are informed that they may send to the undersigned a sum of 37 Naye Paise (6 annas) towards the cost of each copy required, either by money order or in the shape of postage stamps, on receipt of which the copy will be posted to them. A few copies of the 4th, 5th, 6th, 9th, 10th and 11th issues are also available, and may be obtained by sending 37 naye Paise (6 annas) towards the cost of each copy required. Copies of the 1st, 2nd, 3rd, 7th and 8th issues are not available.

C. ARUMUGAM.

328, Raja Street, Coimbatore. | Hony. Secretary IMA. Madras State Branch.

The 35th All India Medical Conference is scheduled to be held at Cuttack during the last week of December 1958. The subject matters selected for the Scientific Session are as follows :—

(*A*) SYMPOSIUM—

1. **Diseases of the Liver**
   (General discussion on Physiological, Pathological and Medical aspects)
2. **Filarial Lymphaedema of Limbs**
   (Discussion on, Pathological, Medical and Surgical aspects)
3. **The role of sterilisation in Family Planning**

(*B*) GENERAL PAPERS—
(Papers on various branches of Medical Science)

Such of those members of the I.M.A. Madras State Branch who are willing to participate in the Scientific discussion are requested to send a brief summary of their paper by 1st November 1958 to **The Organising Secretary, XXXV All-India Medical Conference, S C.B. Medical College, Cuttack, Orissa.**

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MADRAS

Messages . . .

INDIAN MEDICAL ASSOCIATION

CENTRAL OFFICE, DELHI.

President
DR. D. V. VENKAPPA

No. 3. DINADAYALU STREET,
T. NAGAR, MADRAS-17.

The Madras Clinical Journal is rightly termed as such for the very valuable and useful scientific contribution from the pen of eminent and well-known members of the Profession in the Madras State in all branches of Medical Science. The Journal is the official organ of the Madras State Branch of the Indian Medical Association and comprises of interesting articles and lectures delivered at the State Conferences and branches apart from contributions by members. A few pages are allotted to the Association proceedings besides important notifications and communications from the Government and our Association. The unique and outstanding feature is the regular publication every month, which is eagerly awaited by members to whom copies are sent free. It is indeed heartening to note that under the able management of our worthy colleague, Dr. R. Kalamegham the progress made is striking and phenomenal. May I take the opportunity of conveying to him our thanks for his labour of love on the eve of the Silver Jubilee of this popular magazine.

(Sd.) D. V. VENKAPPA.

INDIAN MEDICAL ASSOCIATION,
MADRAS STATE BRANCH.

M. SANTOSHAM, M.B.B.S., F.C.C.P.,
President.

I am very glad to see that the editor of the Madras Clinical Journal is to bring out the silver jubilee number this month.

There are many who think that there should be only one Clinical Journal for the whole of the Indian Medical Association and the publication of journals by State branches is not only superfluous but also inadvisable. The fear of the parent-body of the I.M.A. is that the editorials of the Journals of the State branches may sound discordant with one another in the matters of policy. Such a fear can be overcome by placing a bar on the Journals of the State branches writing editorials on policy matters. A complete ban on the publishing of Clinical material is not only unnecessary but also unhealthy.

The Madras Clinical Journal as the official organ of the Indian Medical Association of Madras State serves many useful purposes. First and foremost it serves as our news sheet giving information regarding the activities of one branch to another and this service helps the district associations to be in the knowledge of the interests of one another. Apart from the provincial Council and the Annual Conferences which meet more rarely the Madras Clinical Journal adds great force in bringing together and consolidating the independantly administered district branches into a single state organization with unified interests and activities.

Secondly this journal provides space for the publication of clinical materials of special interest to the state. The large amount of clinical studies made in the state cannot find space for publication in Journals which serve wider interests and even when published may not reach the hands of all our members.

The Madras Clinical Journal therefore fulfills special purposes and I hope and trust that it will continue to do so for all times.

On the Silver Jubilee day of the Journal I hasten to thank the editors who have worked hard to build the Journal up. Long live the Madras Clinical Journal. Our thanks are also due to the several advertisors through whose co-operation much progress has been possible.

(Sd.) M. SANTOSHAM.

DR. U. KRISHNA RAU
Speaker,
Madras Legislative Assembly

FORT ST. GEORGE,
MADRAS.
5th April, 1958.

I am glad to learn that the Madras Clinical Journal will celebrate its Silver Jubilee shortly. 25 years is an event of which anybody can be proud of, much more so, a medical journal which has to surmount many obstacles and difficulties in the course of its working. Being associated with a journal myself I can appreciate the magnitude of your work when you complete 25 years of useful existence. I am aware of the difficulties which you are encountering in conducting this journal. but I must say that you are doing well.

Please accept my congratulations and my best wishes for the future.

(Sd.) U. KRISHNA RAU.

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DR. V. R. THAYUMANASWAMY,
M.S., F.R.C.S., M. Ch. Orth.,
Director of Medical Services.

MOUNT ROAD,
MADRAS-6.

I am glad to learn that the Madras Clinical Journal will be celebrating its Silver Jubilee very shortly.

As the Journal is reaching every Member of the Indian Medical Association of our State and serves a very useful purpose, I wish it continued success and usefulness under your leadership and able guidance.

(Sd.) V. R. THAYUMANASWAMI.

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DR. Y. P. VASUDEVAN,
M.B., B.S., B.S.SC.

Ex-President, Madras State Branch of
The Indian Medical Association and
DEAN, Kuppuswamy Naidu
Memorial Hospital for
Women and Children, COIMBATORE.

I congratulate the Editor of the Madras Clinical Journal on the occasion of its Silver Jubilee. It is an achievement of development from the purely 'Miscellany' stage to the status of a Clinical Journal. "Knowledge is of two kinds. We know a subject ourselves or we know where we can find information upon it," and the Madras Clinical Journal is one such storehouse out of which one can both chew and eschew. My best wishes for its future and continued usefulness to the medical profession.

(Sd.) Y. P. VASUDEVAN.

Dr. A. ANANTHANARAYANA AYER,
B.A., M.B.B.S., M.SC., F.A.SC.,
Director, Upgraded Anatomy Department

Stanley Medical College,
Madras.
Date : 12th July, '58,

I have been a regular reader of the 'Madras Clinical Journal' and its precursor 'The Miscellany' for many years now. The Journal has provided a medium in South India for the publication of original articles, association lectures, rare case reports, medical news and abstracts from current literature, and has helped to bring the trends of progress in modern medical science into the hands of the busy practitioner. The Editor is to be congratulated for the continuing expansion of the scope and size of the Journal. I wish the Journal an ever increasing prosperity in its career of very useful service.

(Sd.) A. Ananthanarayana Ayer.

* * * *

Dr. R. V. RAJAM,
M.B., M.S., F.R.C.P., F.R.S.,
Director,
Institute of Venereology

Govt. General Hospital,
Madras-3.

" I have great pleasure in sending a message of good wishes on the occasion of the Silver Jubilee of the Madras Clinical Journal.

It is a source of satisfaction that the Journal inspite of the changes in designation and Editorship has continued to be published and within recent years, the quality and the standard of the papers published, have shown progressive improvement.

(Sd.) R. V. Rajam.

M. D. ANANTHACHARY, M.D.,
Principal (Retd.)

MADURAI MEDICAL COLLEGE,
MADURAI.

Three decades of experience in the practice of the profession, perhaps, qualifies me for the expression of my sentiments on the occasion of the Silver Jubilee of the MADRAS CLINICAL JOURNAL. Over that period, I can recount the very inception, conception birth, infancy, adolescence and now, adulthood, of this journal.

Miscellany, to give it its baptismal name, was almost a nondescript mongrel, born under conditions which most uufortunately, so very commonly obtains in our country even today,—indigency.

Its sustenance in early infancy was more nearly the made-up food from foreign sources — extracts from foreign journals and very little else. The inescapable infantile maladies were overcome by its progenitors, whose depth of faith in its ultimate survival and even maturity, was equal to the precariousness of its existence then. As with its counterparts in humans, the environment and nourishment not having proved fatal, promoted the development to diverse diseases ensuring its survival. In this, its association with the fortunes of the Indian Medical Association helped to gain for it, growth and development.

The MISCELLANY reflected to the profession in this state, the activities of the various branches of the I.M.A. and drew its life blood therefrom. As more and more of the profession found it NOT infradig, to help to fill its hungry pages with food for thought, it throve better and reached adolescence and recognition in the eye of the practicing public.

I myself, I regret to say, have been guilty of snobbish upturning of my nose on being introduced to it for the first time and I felt at that time that I was not alone in the way I reacted. Analogous to the education of adolescents, the youthful Miscellany gained by association with the growing profession which, along with the rest of the resurgent national life, was imbued with a national spirit and aspirations. High placed members in the profession began to encourage

development and growth of the younger members in the profession in the native soil. Hence to foster and build up the standards of its organs to international level, was symbolic of the upsurge of national spirit after the attainment of political independence.

It was thus the MISCELLANY found itself engaged in two-fold purpose, alike profitably to itself in its own evolution to maturity, and in helping the profession to bond together into a united Medical Profession.

Aspiring and blossoming adulthood, after the final moult, takes on new names, like stars and starlets in firmaments other than heaven. Likewise, the Miscellany changed its name and face but not its purpose. From being one of a miscellaneous outlook, it adopted the individualistic and representative name and character of the state. The image MISCELLANY changed into the nymph THE MADRAS CLINICAL JOURNAL.

The future has no ceiling. The height to which one can rise has been set in this age of sputniks. The power to send the journal circling round the globe vests with the medical profession of this state. Here, then on the occasion of its coming of age in its Jubilee year the Journal throws an opportunity and a challenge to the rank and file as well as the officers, to surpass rather than maintain, the high regard and respect this state has created in the past history of the medical profession in India and outside.

On this auspicious occasion, I bless the Madras Clinical Journal in the traditional Hindu manner, " Sathamanum bhavati, satayuhu. purushaha satain-driyaha auyushu yeva indriya pratithishtathi ".

(Sd.) M. D. ANANTHACHARY.

DR. R. MAHADEVAN,
M.S., F.R.C.S. (ENG). F.R.C.S., (EDIN).
Prof. of Surgery,
Madras Medical College
Surgeon, General Hospital, Madras.
(Retired)

CHIEF MEDICAL OFFICER &
SURGICAL CONSULTANT
GENERAL HOSPITAL,
MUNNAR P. O. KERALA.

I am very glad indeed to hear that the Silver Jubilee of " The Madras Clinical Journal " will be celebrated soon. I have very great pleasure in saying that it has become one of the very useful and good medical journals, with lot of useful practical information. That it is being sent free to all members of the Indian Medical Association is certainly a matter for congratulation, but I feel if a nominal charge, say about Rs. 5—00 per annum is made, the amount can be utilized for including clinical photographs, X-ray prints etc. in the articles. This will be so useful that I feel the members will gladly pay the amount.

Wishing the Journal continued success.

(Sd.) R. MAHADEVAN.

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DR. R. G. KRISHNAN, F.R.C.S.
DEAN

MADRAS MEDICAL COLLEGE.
MADRAS.
8—4—1958.

I congratulate Dr. R. Kalamegham for having successfully conducted the " Madras Clinical Journal " for the last 25 years. It is not an easy matter to publish a Journal supplied free ; and to conduct it successfully financially. I wish the Journal a long and prosperous life.

(Sd.) R. G. KRISHNAN.

Dr. S. BALASUBRAMANIAN, M.S.
Dean

Stanley Medical College
and Stanley Hospital,
Madras.

The Madras Clinical Journal demonstrably is a vast advance on its predecessor "Miscellany". The Madras Clinical Journal is perhaps thin in its bulk but the quality of its articles has always been of a high standard. They are generally from the Pen of highly qualified Teachers and others in the profession and the articles are of great value in practical application in the day to day work of the General Practitioner. I am sure this Journal reaches the remotest village giving an opportunity even to the modern medical practitioners in remote villages to keep themselves abreast of modern knowledge with ease. The busiest practitioner should also have enough time to go through the pages of the Madras Clinical Journal with interest and profit. I wish the Madras Clinical Journal years and years of useful service to the Indian Medical Association and the profession.

(Sd.) S. Balasubramanian.

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J. C. DAVID, M.B., B.S., Ph.D.
Principal,

Christian Medical College,
Retd. Surgeon General with the
Government of Madras.

I am honoured by the invitation of the editor of the Madras Clinical Journal to send a message on the occasion of its Silver Jubilee. I have watched with great interest the development of this periodical from the original "Miscellany". Now it has become the official organ of the Madras State Branch of the Indian Medical Association. I have always wondered how the editor could afford to send the issues free to quite a number of people.

I have always been interested in the scientific papers appearing in the journal widely varying in the specialities, as well as the very useful 'abstracts' made. All this requires time and work and I have wondered how the editor finds time for all his multifarious activities.

My special interest in the journal also lies in the fact that the editor, Dr. Kalamegam was one of my favourite students in the Madras Medical College.

I do trust that with the support the profession can give, the 'Clinical journal' becomes in the near future one of the foremost medical journals in this country.

(Sd.) J. C. David.

DR. G. D. VELIATH,
M.D., D.T.M. (CAL.)
Principal

THE KASTURBA MEDICAL COLLEGE,
MANGALORE-1.
Date : April 23, '58.

The Madras Clinical Journal is completing 25 years of fruitful service. My hearty congratulations to you and to all those who strove hard to make it a worthy vehicle of Medical thought and experience — specially in South India.

May it continue in ever expanding measure its useful work for the cause of humanity and medical science is my earnest prayer.

With best wishes.

(Sd.) G. D. VELIATH.

* * * *

DR. P. K. GUHA,
M.B. (Cal.), M.R.C.S. (Eng.) D.O.M.S. (Lond.)
Hony. Editor

JOURNAL OF THE
INDIAN MEDICAL ASSOCIATION,
CALCUTTA-13.

In a land where journals, like babies, die young, it is only the sturdiest or the most carefully nurtured that survive their youth and attain adulthood. It is therefore a matter of deep gratification to know that The Madras Clinical Journal is celebrating its Silver Jubilee, under the auspices of the Madras State Branch of the Indian Medical Association.

To conduct a medical journal, as we can say from personal experience, is a great responsibility, a hard trial and not unoften a thankless job.

What pleases me particularly about this Journal, which is excellent in its way, is that the sponsors have refused to combine utility with profit, the whole of which, I understand, is ploughed back into the Journal towards its improvement.

May the Journal continue to serve for many many years to come.

P. K. GUHA.

DR. U. B. NARAYANRAO,
Editor

MEDICAL DIGEST,
BOMBAY-4.
13th May '58.

The Madras Clinical Journal is to be congratulated on its completion of 25 years of publication. As with every Journal, this contemporary had to pass through difficult times and yet facing them with courage and devotion to duty, has surmounted them. Madras State has few medical journals, especially compared to our State, and the success of the Madras Clinical Journal should all the more be welcome. We wish the Journal many more years of usefulness to the profession and the public.

(Sd.) U. B. NARAYANRAO.

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DR. R. B. KARNIK,
Managing Editor

MAHARASHTRA MEDICAL JOURNAL
538, NARAYAN PETH, POONA-2.
19th June 1958.

It gives me great pleasure to find that 'The Madras Clinical Journal' has entered its 25th year of publication and is celebrating its Silver Jubilee this year.

Started in the early twenties under the title of 'Miscellany' and sent free to all from the medical fraternity in the then Madras Presidency, it has steadfastly progressed in its onward march. Some time ago it was recognised as the official organ of the Indian Medical Association, Madras State Branch, and metamorphosed itself under its present name. The toils and turmoils through which an editor of a monthly—and particularly of a medical journal—has to pass are hard experiences for an average man.

It is my firm belief that local journals have a place in medical journalism. These journals give a platform for local talent to come up. It is therefore with a sense of great respect that I look that these journals continue to serve the profession even against great odds.

I wish the Madras Clinical Journal long and prosperous life for realising the ideals set before itself.

(Sd.) R. B. KARNIK.

L. J. LARSON,
Editor

ORIENTAL WATCHMAN AND HERALD OF HEALTH
P.B. 35, POONA-1.

Thank you for your letter of the 8th April which I have gone through with a good deal of interest and I assure you that I am happy to send a short message for your Silver Jubilee number.

The Editor and staff of the *Oriental Watchman and Herald of Health* wish at this time to congratulate the *Madras Clinical Journal* on its 25 years of service to the medical profession of South India.

We receive the publication regularly and go through its pages with interest.

We wish the Journal continued success through the years to come.

(Sd.) L. J. LARSON.

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J. P. CORREA,
Natural Science Assistant

United Nations Educational,
Scientific and Cultural Organisation
SOUTH ASIA SCIENCE CO-OPERATION OFFICE,
21, CURZON ROAD, NEW DELHI.
9th April, 1958.

Thank you for your letter of 7th April, 1958, informing us that the 'Madras Clinical Journal' is to celebrate its Silver Jubilee shortly.

We are glad to congratulate you for this remarkable progress already achieved by your journal which is now the official organ of the Madras Branch of the Indian Medical Association.

The Progress of scientific publications in this region is of considerable interest to our office which as you are aware is publishing the monthly Bibliography of Scientific Publications of South and South East Asia.

We wish your journal continued success in the future.

(Sd.) J. P. CORREA.

REVIEW

" MEDICINE IN ITS HUMAN SETTING "

By

A. E. CLARK KENNEDY,

Faber and Faber Ltd., 24, Russell Square, London.

Professor Clark Kennedy's book " Medicine in its human setting " is a treasure house of fundamentals of clinical medicine. He has so woven his stories that each one has a particular medical subject as its theme. In the 272 pages of bold print he has attempted to cover a number of diseases which have a congenital infective, traumatic, neoplastic or psychosomatic basis—and indeed very creditably he has achieved his object of presenting a book of this kind.

Clinical medicine should be taught to us in this fashion in our medical colleges during the infant years of our student career. His approach to a disease problem from its beginning to its termination, the elucidation of symptoms and signs, their interpretation with reference to underlying pathology, the correlation of radiological and other laboratory tests, the recognition of the limitations of therapeutics both in hospital and in general practice are admirably brought out in this book. His descriptions of the many medical jargons in simple understandable terms is something which will be very appealing to the recruit entering the medical profession. The necessity of understanding and treating the patient as a whole and not his diseased organ alone is well stressed. The whole book picturises as it were the science, art, mistakes, humour, limitations and tragedies of medical practice.

The essential requisites of a general practitioner are so vividly protrayed in the role of Dr. Fetchquick—the name itself is so apt to indicate what he can be called upon to do. The understanding, tact, presence of mind, integrity, humility and above all a thorough knowledge of the subject that are demanded of any medical man have been given full expression to in this book through the medium of doctor characters that we meet with in the various stories. Public Health problems relating to school, factories, small communities and so on are analysed. How uptodate equipment and facilities help in averting major catastrophies in hospitals are noticeable when we read some of the anecdotes. Also we see how in spite of the untiring efforts of the medical man, the incurable diseases do defy our knowledge and escape out of our hands.

Particularly the stories relating to a mother suffering from mitral stenosis, the description of the various types of nephritis, the picture of a G.P.I. case and the onset and course if Disneminated Sclerosis in a doctor's wife are masterly ones from the pen of Dr. Clark Kennedy.

Through this book he has tried to lay great emphysis on doctor–patient relationship which we all agree is the key note of success in medical practice. One is bound to be profited by reading this book which comes from the pen of a philosophically minded physician and an outstanding clinician to whom a generation of doctors owe something of their knowledge. To every student of medicine to whichever speciality he may belong to, I strongly recommend this book and it should be considered as an invaluable addition to one's library.

(Sd.) C. V. RAMAKRISHNAN, M.B., B.S., T.D.D.(M), Madras.